



NASTAD

National Alliance Of State And Territorial AIDS Directors

8

Hepatitis A and Hepatitis B

Vaccines

Hepatitis A and Hepatitis B Vaccines

Vaccines to prevent hepatitis A virus (HAV) and hepatitis B virus (HBV) infections have been commercially available in the United States since 1995 and 1982, respectively. However, HAV and HBV infections continue to be among the most prevalent vaccine-preventable diseases.

Hepatitis B vaccination of infants is now a routine practice in the United States and recommendations for early adolescent immunization have resulted in school entry and 7th grade vaccination requirements in most states. Hepatitis A vaccination of children aged 2 years and older varies from state to state. Targeting children in areas where there have been historically high hepatitis A rates has been an effective strategy in decreasing the incidence of hepatitis A in the United States. However, there remain sizable numbers of unvaccinated older adolescents and young adults engaging in behaviors that put them at risk of both hepatitis A and hepatitis B. Increasing the number of at-risk adolescents and adults that are vaccinated could result in significant benefits for society. For example, CDC estimates that for every 1 million at-risk adults vaccinated for HBV:

- 50,000 new HBV infections are prevented;
- 1,000 to 3,000 chronic HBV infections are prevented;
- 150 to 450 deaths from cirrhosis and liver cancer are prevented; and
- \$100 million in future, direct medical costs (discounted) is saved.

Many people, both in the general public and in the health care community, associate vaccination programs with children. Other than annual flu vaccination campaigns, there are few vaccine initiatives targeting adults. Various challenges exist when attempting to vaccinate adult populations. Many adults do not seek preventive medical services for various reasons, whether it is the lack of health insurance or not wanting to take time off work. Therefore, they do not come into contact with practitioners who are focused on preventive medicine. At an infrastructure level, there are few adult vaccine tracking systems and no national surveillance for adult vaccine coverage, which

Who Should Be Vaccinated

Hepatitis A

- Injection and non-injection drug users
- Travelers to places with high rates of HAV infection (Africa, Central/South America, Asia, Middle East, Russia)
- Gay Men/Men who have sex with men (MSM)
- People with clotting-factor disorders (hemophilia)
- People with any type of chronic liver disease
- People waiting for or who have had a liver transplant
- Children living in areas of the U.S. with historically increased rates of hepatitis A

Hepatitis B

- All babies, at birth
- All children, aged 0-18 years old, who have not been vaccinated
- Injection drug users (IDUs)
- Sexually active heterosexuals (more than one partner in prior six months, recently acquired STD)
- Gay Men/MSM
- Sex contacts of people with chronic hepatitis B
- Household contacts of people with chronic hepatitis B
- People with jobs involving contact with human blood
- Kidney dialysis patients and patients with early renal failure
- Families of children with evidence of past infection who have been adopted from areas with high rates of HBV infection (Southeast Asia, Africa, Amazon Basin, Pacific Islands, Middle East)
- Those traveling or living internationally for more than six months in areas with high or intermediate rates of HBV infection
- Inmates in correctional facilities
- Clients and staff of institutions for the developmentally disabled

further complicates obtaining useful data on adult vaccination. Finally, there is an ongoing need to educate adults and their providers about vaccination. The lack of awareness on the part of both adults and providers creates a significant barrier when promoting the vaccination of at-risk populations.

MISSED OPPORTUNITIES

Efforts are underway to reach adults at risk for HAV and HBV infections. However, many adults go unvaccinated because of a lack of resources and other reasons. At-risk adults account for more than 75 percent of all new cases of HBV infection each year.

Currently, public health initiatives to vaccinate at-risk adults are a bit like orphans. State and local health department immunization programs tend to focus on children; this has traditionally been their mandate from CDC, and federal immunization funds overwhelmingly support infant and children vaccine initiatives. Due to similarities in affected populations and means of transmission, HIV/AIDS and STD programs are increasingly responsible for administering viral hepatitis services. While these programs have the expertise to reach at-risk adults, sufficient resources have not been available to carry out comprehensive viral

hepatitis programs that include vaccination. In many areas, no one has really taken “ownership” over viral hepatitis services.

Non-traditional vaccination sites such as STD clinics, correctional facilities, substance abuse treatment centers, homeless shelters, HIV counseling and testing sites, and mobile outreach activities all provide opportunities to vaccinate adults at risk. Studies have found that over half of those newly infected with HBV have accessed services in public health settings, where vaccination could have also been provided. Of all individuals with reported acute hepatitis B, 37 percent reported prior treatment of an STD, 29 percent reported prior incarceration and 56 percent had been treated for an STD and/or incarcerated in prison or jail prior to their illness. Studies indicate that there is a 70 to 85 percent acceptance rate of the first dose of hepatitis B vaccine among IDUs and STD clinic clients, and at HIV counseling and testing sites and correctional facilities. Clearly, these populations are receptive to preventive measures and these settings represent missed opportunities for disease prevention.

There are various reasons why non-traditional sites do not offer vaccination. Vaccination programs require the purchase and storage of vaccine, infrastructure to deliver vaccine, provider and patient education, and evaluation. The allocation of additional resources would address some of these requirements but providers and staff must also understand the importance of vaccination. In a survey of vaccination practices in 36 state and federal correctional systems, representing over 75 percent of the prison population, only three of 36 respondents offered the hepatitis B vaccine to all inmates. Twenty-five (25) of 34 said they would do so if vaccines were supplied at no cost.

Integrating hepatitis A and hepatitis B vaccination into existing HIV, STD, and other services is not without challenges. These settings may lack personnel that are qualified to administer vaccine. Counseling and education staff may already be overburdened. In addition, educating clients about viral hepatitis is complicated (e.g., various types, complex disease progression, etc.) and some degree of screening may be necessary prior to vaccination. However, given the risk of infection for those who participate in high-risk behaviors, the gravity of the illness, and the cost of treatment, providing resources to organizations with ties to at-risk populations to carry out adult vaccination programs clearly appears to be a cost-effective response.

THE ROLE OF STATE HEALTH DEPARTMENTS

In December 2003, the National Viral Hepatitis Roundtable held its inaugural meeting to begin developing a national strategy for the elimination of viral hepatitis. The vaccination of at-risk adults will be a critical component. At the meeting, participants identified specific efforts that states should be, and many are, undertaking. These include:

- Working to ensure that HIV and STD programs train their staff on viral hepatitis;
- Training frontline counselors to incorporate HAV and HBV prevention messages into counseling sessions;
- Establishing referral networks and linkages to vaccine services in the community; and
- Capitalizing on resources from other public health programs to implement vaccine programs.

Some states dedicate their own funds to viral hepatitis prevention efforts. Others rely on creative solutions that help stretch resources. However, when activities are instituted with “one-time” funding or cobbled together with insufficient resources, sustainability can be an issue. Tenuous funding can prevent buy-in from necessary partners. It can also create high expectations that cannot be met. This can impact future collaborations.

An important part of the nation’s response at the state level is the role of hepatitis C coordinators. The CDC’s Division of Viral Hepatitis (DVH) provides 48 states, the District of Columbia, three cities and the Indian Health Service (IHS) funding for a hepatitis C coordinator position. Hepatitis C coordinators are charged with assisting state and local health departments in identifying public health and clinical activities in which viral hepatitis education, prevention and services (i.e., hepatitis C counseling and testing, hepatitis A and B vaccine) should be incorporated. Hepatitis C coordinators can play an important role in facilitating collaboration between state health departments and non-traditional sites.

ROLE OF COMMUNITY-BASED ORGANIZATIONS (CBOs)

Why integrate viral hepatitis prevention with other programs? Many community-based organizations (CBOs) serve populations that are also at risk of viral hepatitis due to their various high-risk behaviors such as injection drug use or sex with multiple partners. Coordination would eliminate missed opportunities for prevention, which lead to ongoing transmission of viral hepatitis.

Getting more organizations involved in viral hepatitis prevention requires resources. Vaccines for Adults at Risk for Hepatitis (VFARH), a four-Center CDC initiative, has been collecting hepatitis A and hepatitis B vaccination data from 48 states and several cities and territories over the past few years. The data revealed that an estimated three million people are currently receiving services in public sector STD and HIV prevention facilities, nationwide. Based on risk and susceptibility data, it is estimated that approximately 383,000 doses of hepatitis A vaccine and 3.75 million doses of hepatitis B vaccine would be needed to protect these people.

In addition, there are barriers to collaboration that do not relate to resources. Some CBOs may not be aware that the populations they serve are at risk of viral hepatitis. Even if they are aware, they may not know that vaccines are available for viral hepatitis or that they can play a role in disease prevention. Providers with expertise in viral hepatitis need to reach out to these potential partners and educate them about roles they can play.

In building relationships with other organizations within a community, it is important to determine appropriate collaborative roles. Not every organization serving at-risk adults needs to provide vaccination services. For some, referring their clients to another organization is the most appropriate course of action. Others will have the capacity to provide vaccination but will need technical assistance in implementing a program. Vaccination can be somewhat intimidating if an organization is not familiar with the process. Staff will require training and protocols will need to be modified. For example, the implementation of a vaccination program will require an additional level of paperwork for staff. This includes: informed consent forms, vaccine information statements (VIS), notations in medical chart, documentation of reasons for vaccine decline, appointment reminder card, and maintenance of immunization record.

Innovative approaches should also be considered. Personnel can be outsourced to organizations that do not have the staff capacity to provide vaccines, making vaccinations available to clients on a regular basis. Stationing mobile outreach vehicles at collaborating organizations has also proven effective.

Resources to facilitate the process of educating and tracking patients are available from the CDC and organizations like the Immunization Action Coalition. The Immunization Action Coalition has developed a step-by-step guide for organizations implementing adult immunization. The guide is available at:
< <http://www.immunize.org/guide/index.htm> >.

ROLE OF PRIVATE PROVIDERS

Many at-risk adults do not seek services from CBOs. Instead, they receive their health care from private providers. These providers can play a vital role in the prevention of viral hepatitis. Unfortunately, all too often these providers are not aware of who should be vaccinated and even if they are, they do not perceive their patients to be “at-risk.” Private providers need to be educated about conducting risks assessments and identifying when it is appropriate to vaccinate their patients that are at risk for viral hepatitis. These providers also need information on how to effectively educate their patients about viral hepatitis since patients may be unaware of the risk as well.

Unfortunately, in addition to the issues related to awareness mentioned above, there are also some disincentives for private providers when it comes to offering their patients vaccinations for viral hepatitis. Stocking vaccines requires that private providers cover the costs upfront. The vaccines must then be properly stored, which requires space and monitoring. For patients with private insurance that are vaccinated, a claim must be submitted, which the insurer may or may not reimburse. If the insurer does not pay, the private provider must obtain payment from the patient. To avoid the possibility of not being reimbursed, some private providers write a prescription for the vaccine, which the patient then fills. While this makes sure that the private

provider is not left “holding the bag” financially, it does create extra steps that only the most motivated of patients will take.

The American Medical Association has resources available for private providers on its web site. < <http://www.ama-assn.org/ama/pub/article/2347-8586.html> >.

Vaccine Basics

Hepatitis A Vaccine

Date available: 1995

Dosage: Two doses, 6 to 18 months apart

Immunity: Protective antibody levels developed in 94% to 100% of adults 1 month after the first dose. After the second dose, all persons have protective levels of antibody.

Private-Sector Cost per Dose: \$52 to \$62

Insurance Coverage: Many insurers offer coverage for at-risk populations. Coverage and reimbursements vary among insurers and individual insurance plans.

Guidelines: Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP)

< <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4812a1.htm> >.

Hepatitis B Vaccine

Date available: 1981

Dosage: Three doses, over a 6-month period

Immunity: 1 dose, 30% to 50% protection; 2 doses, 50% to 75% protection; 3 doses, more than 90% protection. Note: some people, such as people living with HIV, may require more than three doses.

Private-Sector Cost per Dose: \$48 to \$59

Insurance Coverage: Many insurers offer coverage for at-risk populations. Coverage and reimbursements vary among insurers and individual insurance plans.

Guidelines: Hepatitis B virus, a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccinations: recommendations of the Advisory Committee on Immunization Practices (ACIP)

< <http://www.cdc.gov/mmwr/preview/mmwrhtml/00033405.htm> >.

Combined HAV/HBV Vaccine (Twinrix®)

Date available: 2001

Dosage: Three doses, over a 6-month period.

Private-Sector Cost per Dose: \$77 per dose

Twinrix® is indicated for vaccination of persons 18 years of age or older.

With all viral hepatitis vaccines, there is a minimum amount of time needed between doses, but there is no maximum. Patients never need to restart the series.

Vaccine Financing

- **Vaccines for Children**

In 1994, the federal Vaccines for Children (VFC) means-tested entitlement program began. The VFC program, funded by Medicaid and administered by CDC's National Immunization Program, provides free vaccine to VFC-eligible children. Eligible children include the uninsured, Medicaid recipients, Native Americans, or Alaska Natives at their doctors' offices. VFC also provides immunizations for children whose insurance does not cover immunizations at participating federally qualified health centers (FQHCs) and rural health clinics (RHCs).

- **317**

The "317" discretionary grant program is a federal immunization program that may be utilized to support adult vaccine purchase. 317 funds are used to support both activities at the CDC's National Immunization Program and grants to states, territories and selected metropolitan regions (total 64 grantees). 317 funds can be used to purchase vaccines for disadvantaged populations and to support immunization infrastructure, including professional education, outreach, surveillance of coverage levels and vaccine safety, and efforts to improve coverage rates in child and adult populations. Because there are no eligibility requirements for 317 funds, these funds may be used to support adult vaccine initiatives. Despite the VFC program, there remains a population of "underinsured" children who are not able to obtain vaccines without assistance and 317 funds can also be used to fill this gap. The 317 grant program does not require matching state funds.

Organizations receiving vaccine through VFC or 317 need to comply with specific accounting and administration rules and regulations. For example, organizations cannot charge for the actual dose of vaccine, although they can charge a dose administration fee. All patients receiving federally purchased vaccine must read a Vaccine Information Statement (VIS). The statements provide information on the vaccine, including possible side effects. VIS statements are available from the CDC.

State and Local Funding

Some states also use their own funds to support vaccination. Half the states use state funds to purchase less than 10 percent of the vaccines provided to disadvantaged populations. Ten states use their own funds for more than 30 percent of such vaccines.

About Vaccines

History of Vaccination

Attempts to vaccinate have been traced back to the sixth century. A little over 200 years ago, Edward Jenner developed the first vaccine by using cowpox to immunize against smallpox. Almost 100 years later, Louis Pasteur proved that protection against disease could be provided by the introduction of weakened germs that cause a relatively harmless infection. In 1885, Pasteur treated a boy that had been bitten by a rabid dog with a vaccine that prevented the development of rabies. Vaccine research continued during the remainder of the 19th century. It was discovered that in addition to using weakened viruses to make vaccines, they could also be made with dead viruses.

As with many scientific developments, vaccination was not without controversy. There were many in both the scientific community and the general public who vigorously opposed the deliberate introduction of deadly viruses into humans. These opponents organized in opposition to the new vaccines. However, by World War I, general vaccination had become routine.

Misconceptions and Fears

Most people recognize the benefits of vaccination. Nonetheless, there are those who question the safety and efficacy of various vaccines and are reluctant to get vaccinated. Some of the common misconceptions and fears that practitioners might encounter are listed below.

I feel fine/I never get sick

If a person is not feeling sick, they may see vaccination as unnecessary.

You may get the disease from the vaccine

The use of weakened or dead virus in vaccines has resulted in fears, by some, that you can actually get the disease that you are being vaccinated against from the vaccine.

I don't like putting chemicals in my body

Some people prefer an alternative or homeopathic approach to health and view vaccines as harmful.

There are dangerous side effects

Serious reactions to vaccines are extremely rare. The risk of developing a disease as a result of failing to get vaccinated is far greater than the possibility of serious reaction to a vaccination. Some debates about the dangers of vaccination have received considerable media coverage. For example, in recent years there has been an ongoing debate on whether autism is related to childhood vaccination. There is no scientific evidence to support this link but the controversy has continued.

You can still get the disease, even if you are vaccinated

No vaccine is 100 percent effective and not all vaccinated persons develop immunity. However, the vast majority of people who are vaccinated develop immunity.

In addition to the misconceptions and fears listed above, there are some religions that oppose vaccination, such as Christian Scientist and the Amish. Also, certain racial/ethnic populations may be weary of vaccines as a result of negative health-related experiences. For example, the legacy of the Tuskegee study has continued to have an impact on the views of many African Americans.

Needle Fears

Finally, don't underestimate the role the needle plays in some people's resistance to getting vaccinated. Fear of needles has been reported in studies as a reason people have declined vaccination. While this is not a significant factor in why people decline to be vaccinated, practitioners should be aware of it and be prepared to possibly spend a little more time explaining the benefits of vaccination to their patients that are "needlephobic."

Who Needs to be Educated

Various types of awareness efforts are required in order to support viral hepatitis prevention activities.

Non-Traditional Sites

Organizations providing services to at-risk adults need to learn about the role they can play in the prevention of viral hepatitis. Basic information must be provided in order to educate them, and they must receive training on the provision of viral hepatitis prevention services in order to develop their capacity.

Private providers

Since some at-risk adults receive their health services from private providers, these providers need to be educated about who is at risk so

they can conduct risk assessments and offer vaccines or referrals as appropriate.

At-Risk Populations

Health education and outreach activities need to target at-risk adults to inform them about the risks of viral hepatitis and the availability of vaccines. Studies indicate that when at-risk adults are educated about viral hepatitis they are receptive to vaccination. The importance of raising awareness cannot be underestimated. Some viral hepatitis vaccination initiatives at the local level have experienced limited success because not enough emphasis was placed on raising awareness and educating the target population about the risks of viral hepatitis. As a result, many in the targeted populations went unvaccinated.

Screening Prior to Vaccination

If someone has already been vaccinated against HAV and/or HBV or is already infected, then vaccination is unnecessary. Unfortunately, many people do not know if they are infected and it is fairly common for people to forget whether they have been vaccinated, especially when it comes to whether they completed the multi-shot series.

The cost effectiveness of screening can be determined by three factors:

- Cost of immunization;
- Cost of testing for prior infection; and
- Prevalence of infection within at-risk population.

However, there are other factors related to screening. Screening places additional demands on providers, who may already be struggling to implement a vaccination program. Additionally, for many of the populations targeted, there is a strong possibility that the client will not return for subsequent appointments, especially in some non-traditional settings. Given that even one shot of both hepatitis A and hepatitis B vaccines provides some immunity in most individuals, some providers argue that it should be provided without screening or that vaccination and screening should be conducted at the same time. If the screening indicates immunity or infection, there is no need for additional doses. Current guidelines support this approach. A drawback of not screening for HBV is that clients that are chronically infected with HBV will not learn of their status and be able to take steps to protect others from infection.

SECTION II: AT-RISK POPULATIONS

Activities that specifically target adults that engage in high-risk behaviors have various advantages. These activities target people at greatest risk of infection and, as has been mentioned previously, venues already exist where hepatitis initiatives can be implemented. Activities targeting people at risk have proven to be effective, both in terms of disease prevention and cost.

When targeting adults that engage in high-risk behaviors, it is important to recognize that there are many sub-populations within these groups. For example, gay men/men who have sex with men (MSM) and injection drug users (IDUs) living in rural areas may require different outreach techniques than their urban counterparts. Multiple approaches may be necessary to address the diversity of at-risk populations.

To get an idea of what activities may already be underway in your community, check out Hepclinics.com. This web site provides a state-by-state listing of free or low-cost vaccination sites.

< <http://www.hepclinics.com/templates/1087834734906664639710/hepclinic/index.html?trycookie=1> >

Why People Get Vaccinated

- Desire to be protected against infection
- Fear of infection
- Time and situation in which it was offered (convenience)
- Partner is getting vaccinated

Why People Refuse Vaccination

- Health beliefs related to infection or vaccination
- Time constraints
- Worries about privacy
- Concerns about side effects
- “Just don’t want it”
- Not aware of the risk
- Dislike of needles and pain
- Concerns about “mixing drugs” or refusal to put chemicals into the body
- Perceived low risk for infection
- Pregnancy or nursing
- Distrust of medical technology

Gay Men and Men who have Sex with Men

Gay men and men who have sex with men are at elevated risk of becoming infected with HAV and HBV through sexual contact. The CDC's 2002 STD treatment guidelines call for comprehensive STD prevention services for MSM, including testing for HIV, syphilis, gonorrhea, and chlamydia at least annually, and vaccination against hepatitis A and B.

Ongoing gay men/MSM viral hepatitis education and vaccination programs have had some success. In 2000, 35.5 percent of MSM respondents in a survey conducted by the Gay and Lesbian Medical Association reported that they had received two doses of hepatitis A vaccine, compared with 22.3 percent reported in a similar survey in 1999. For hepatitis B vaccination, 38.9 percent reported receiving the three-dose series in 2000, compared to 33.4 percent in 1999. However, many health care providers and MSM remain unaware of the risks posed by HAV and HBV infection and the vaccination options available.

There are many opportunities at various venues to reach gay men/MSM and provide viral hepatitis services. The most successful approach to gay men/MSM vaccination is to identify, screen and vaccinate gay men/MSM as they access health care for other reasons: HIV testing, STD screening and treatment, or routine physical examinations. This type of integration of services, where the standard of care is vaccination of all at-risk adults, has proven successful in many venues, most notably, in primary care clinics serving the gay population.

Many gay men and MSM seek care from private physicians. Others go to health centers serving the gay community or HIV clinics. According to data from outbreak investigations and cross sectional surveys among MSM, 54 to 85 percent have a regular source of health care where prevention services could be provided. Unfortunately, a large percentage of gay men/MSM diagnosed with HAV or HBV accessed health care within 12 months prior to their infection, yet had not been vaccinated.

Stigma and homophobia can create challenges to reaching this population. With private providers and in

public-health settings, some gay men/MSM may not want to disclose their high-risk behaviors and providers may be uncomfortable taking a complete sexual history from their male patients, which would include asking the gender of sexual partners. MSM who do not identify themselves as gay or bisexual may be wary of accessing services at a gay-oriented community clinic. Private physicians whose practices include a large proportion of gay men appear to be better educated about vaccinating against viral hepatitis. These physicians may also be seeing a larger number of patients with hepatitis, which brings home the risk gay men and MSM face.

CBOs serving the gay community are important resources in reaching gay men/MSM. Many of these organizations have a long history of providing health and education services to gay men/MSM, including viral hepatitis education, outreach and vaccination. In addition to helping reach the target population, these organizations can also be valuable in educating private providers. For example, Callen-Lorde Clinic in New York City does targeted mailings to physicians to let them know that they can refer their gay men/MSM patients to the clinic for vaccination. This strategy serves both to educate providers about the need to talk to their gay men/MSM patients about viral hepatitis and also lets them know where clients can get vaccinated if the physician does not provide this service. Patients are more likely to follow through on a referral if they have the name of a provider instead of having to research vaccination sites.

Other programs take vaccination efforts out into the community. Gay Pride events, held across the country each year in June, are a very good way to reach large numbers of gay men. At the 2004 Gay Pride Festival in Kansas City, 243 men were vaccinated through a program supported by the Kansas City Department of Health. At New York City's Gay Pride Day Parade, riders on the Callen-Lorde Health Center's float handed out more than 30,000 stickers promoting vaccination. Callen-Lorde also had a booth at the Gay Pride Festival where stickers and brochures were distributed. Other outreach venues that have proven effective for reaching gay men/MSM include bars, gyms, bathhouses, and bookstores. Some organizations conduct awareness activities at these venues. Others provide a wider range of services such as HIV counseling and testing, STD screening, and vaccination for viral hepatitis. These services can be conducted onsite or via a mobile van.

For more information on reaching gay men/MSM go to:

GayHealth.Com

< <http://www.gayhealth.com> >

Gay and Lesbian Medical Association

< <http://www.glma.org> >

Immunization Action Coalition

< <http://www.immunize.org> >

The Gay and Lesbian Medical Association also has available patient education materials targeting gay men/MSM.

CDC Launches National Effort to Prevent STDs in Gay Men/MSM

In spring 2004, CDC launched a national campaign to increase the immunization rate for vaccine-preventable hepatitis in gay men/MSM and other at-risk populations. The campaign was kicked off with a “Dear Colleague” letter from the Department of Health and Human Services urging all its partners at the federal, state, and local levels to promote and implement comprehensive interventions to prevent STDs among the gay men/MSM population, including immunization against vaccine-preventable hepatitis.

CDC has created a pocket information guide for vaccinating gay men/MSM and other at-risk populations against vaccine-preventable hepatitis and a wall poster with the same information, designed for clinical settings. In order to complement this program, the American Medical Association (AMA) has created a tri-fold pocket guide with information on appropriate coding of insurance claims related to immunizing at-risk populations against vaccine-preventable hepatitis.

For more information on CDC’s initiative go to:

< <http://www.cdc.gov/ncidod/diseases/hepatitis/msm/index.htm> >.

For more information on the AMA resources go to:

< <http://www.ama-assn.org/ama/pub/article/2347-8586.html> >.

Incarcerated Individuals

Correctional facilities provide another opportunity to reach at-risk adults. People who are, or have been, incarcerated have high rates of both hepatitis A and B and hepatitis A and B outbreaks have been known to occur in correctional settings. Many people who are incarcerated have a history of high-risk behaviors.

One of the challenges in collaborating with correctional facilities is that they have a different mission, organizational structure and mindset from public health and community organizations. This does not mean collaboration is impossible. However, it may take longer to build a relationship, and the parties involved must recognize each others' priorities.

In addition, some people argue that correctional facilities may not be the best site to reach at-risk adults. Many of the adults coming into the system have already been exposed to hepatitis A and B, and therefore, do not need to be vaccinated. In addition, incarcerated individuals may spend less than six months in the facility, due to either release or transfer, which makes it difficult to complete the series.

In 2001, the Indiana State Legislature provided \$1.5 million in funding to the Department of Corrections to implement HIV, hepatitis C and syphilis screening for all incoming inmates. Offering hepatitis B vaccinations to incoming inmates for a one-year period was also included in the legislation. Screening for hepatitis B was not conducted.

The vaccination efforts had mixed results. There was a sense that vaccination in this population was not cost effective due to the high prevalence of hepatitis B exposure in the population. Providing screening would have been logistically difficult and an additional expense. Even with what is considered "a captive population," follow up was an issue due to transfer and release. Many inmates with sentences of less than six months were not offered the vaccine since subsequent doses could not be administered. Currently, vaccination is only offered to inmates that test positive for hepatitis C. The State used \$450,000 in carry over funds from these efforts to make vaccination available in STD clinics (see below).

Injection Drug Users

Injection drug use is a highly effective means of transmitting hepatitis B and C and IDUs have higher than average rates of hepatitis A infection. Some studies have shown as many as 50 to 70 percent of IDUs become infected with HBV within 5 years of initially injecting drugs. Accordingly, IDUs have some of the highest prevalence rates of liver disease.

Stigma plays a significant role in efforts to reach IDUs. Many argue that this is a population that is exceedingly difficult to reach, will not take protective measures, and are often lost to follow up. However, studies indicate the opposite. When provided the opportunity to protect their health, whether it is through the adoption of safer injection techniques like the one-time use of sterile syringes or by getting vaccinated against hepatitis A and B, many prevention efforts targeting IDUs are successful. In studies, researchers have found various facilitators in getting IDUs vaccinated. These include: expedited appointments (being seen before other clients to minimize waiting time); free transportation to vaccination sites; incentives for each dose; flexible immunization schedules (higher vaccine doses and accelerated schedules); and one-stop shopping at service providers.

IDUs are reached in a variety of settings, including drug treatment programs, correctional facilities and STD clinics. However, one of the most effective sites for reaching IDUs are syringe exchange programs. Syringe exchange is one component of harm reduction, an approach that promotes alternatives to reduce the harm associated with a behavior. A key to harm reduction is providing services in a respectful, nonjudgmental manner.

While the main objective of most syringe exchange programs is to provide sterile syringes to IDUs, many have expanded their service over time to offer screening for viral hepatitis and other STDs, vaccination for hepatitis A and B, information on safer injection techniques, overdose prevention, and referral to other services such as health care, housing, drug treatment, and legal aid. The expansion of services depends heavily on the availability of resources.

The Chicago Recovery Alliance (CRA) provides a range of services throughout the city using large vans as mobile outreach sites. Over the last five years, hepatitis A and B vaccines have been available to clients. The vaccine is provided by the health department so CRA can offer the vaccinations free of charge. The entire outreach staff has been trained to provide vaccinations. Since they have been available, over 2,500 clients have been vaccinated. The completion rate for the three-dose series is 84 percent, which is much higher than the completion rates achieved in most other non-traditional vaccination settings. CRA believes that this level of success has been achieved because of their respectful and long-term connection with their clients.

Syringe exchange programs tend to build a strong rapport with clients. While clients may initially come in only to exchange syringes, over time trust develops and clients take advantage of the other services offered such as HIV counseling and testing or referral to drug treatment.

CRA stresses educating clients about multiple ways to reduce their risk, whether through the adoption of safer injection techniques, the use of sterile injection equipment in addition to syringes (provided by CRA) or by practicing safer sex (CRA provides condoms and lubricant). "Since the clients trust us, they also tend to trust what we tell them," states Dan Bigg of CRA. "One reason why many of our clients get vaccinated is that we have a long-time relationship with them."

Recently, the local health department had a supply of vaccine available that was due to expire. CRA contacted methadone treatment programs to arrange onsite vaccination for clients. While over 300 people were vaccinated, according to Bigg there was a significant difference between working with the clients at the methadone sites and working with CRA's own clients.

"At the methadone sites, the clients didn't know who we were and they had generally not been educated about the risks of viral hepatitis," states Bigg. "The completion rate for the whole series was about 40 percent, which is still good, but in our experience it is more effective to integrate viral hepatitis education and vaccination into a program on an ongoing basis."

"Ideally, the best people to conduct vaccination efforts are those working within the program who have earned the trust of clients and have the opportunity over time to offer and complete the vaccination series," adds Bigg.

Learn more about CRA's services for IDUs at:
< <http://www.anypositivechange.org/menu.html> >.

Homeless

Homeless people are confronted by many challenges, including high rates of mental illness, substance abuse and HIV. Services targeting homeless people, including health care for the homeless services, provide an opportunity to reach this population. In addition, homeless people can be reached through services that address their other needs, such as drug and alcohol treatment providers, HIV/STD clinics, and mental health services. Because of their homeless status, this population is at increased risk of being lost to follow up so any contact they have with providers should be viewed as an opportunity to initiate vaccination.

Sexually Transmitted Disease (STD) Clinics

People seeking treatment in STD clinics have obviously engaged in behaviors that would also put them at risk of HAV and HBV. Since these individuals are seeking treatment in a clinic, they may not have access to any other health care providers. The clinic visit may be a rare opportunity to offer viral hepatitis services.

Studies indicate that vaccination acceptance rates in STD-related settings vary significantly, from 23 to 69 percent. Variables include how it was offered (integrated into the treatment encounter as opposed to being offered by the researchers) and the setting (onsite or through referral).

The studies indicate that onsite vaccination is particularly effective. Even when studies offered incentives or provided transportation, many patients did not follow through on referrals when it entailed going to a different site. Health department clinics that have created linkages between their STD and immunization programs have found that some clients do not follow through on a referral that involves going to a different room in the health department's facility—they just walk out the door. Clearly, strategies are necessary to, 1) educate about

the importance of vaccination so that patients recognize the benefits of vaccination and are sufficiently motivated to follow through on referrals; and 2) facilitate the referral process.

The need to develop effective referral strategies can be avoided by integrating vaccination into STD treatment protocols. The Indiana State Department of Health makes vaccines available to STD service providers using carry over funds from a program that provided vaccines in correctional settings. The funds, totaling \$450,000, should last about two years.

Initially, the health department made vaccine available to any county offering STD services. Currently, 13 providers are participating. The providers request the vaccine from the health department, which then orders the vaccine. The vaccine is shipped directly to providers.

According to Cheryl Percy, Hepatitis C Coordinator, almost all the providers were very receptive to integrating the vaccines into their services. Percy had already been working with the providers to integrate hepatitis C screening into their services. "I built on these previous efforts and it really seemed to help that there was an awareness about hepatitis-related issues," she reports. The health department did have to provide some information about vaccination to the clinics. In addition, some materials, such as order forms for vaccine, had to be developed.

The STD service providers do not screen for prior exposure to hepatitis A and B. Logistically, the screenings are not possible, nor are they cost effective. Currently, the state lab does not have the capacity to conduct screening for hepatitis A and B. If the screenings were conducted, there would be a very long turn around time, in which the client could be lost to follow up. When clinics have conducted screenings, they have found that there is very little immunity in the client population.

Since many young people seek services from STD clinics, it is important to have policies in place addressing whether they can be vaccinated. Most states have laws that allow minors to consent to STD services. However, whether vaccination is considered an "STD service" can be interpreted differently. Programs should be sure to determine if minors require parental consent. In Indiana's case, the determination was made that vaccination was STD treatment, opening the door to use VFC funds to cover the costs. This issue was a major concern to the largest STD service provider in the state, which was reluctant

to take part in the vaccination program until it was resolved.

A manual on integrating vaccination into STD services, developed by the Health and Human Services Agency of San Diego County is available at:
< <http://www.cdc.gov/ncidod/diseases/hepatitis/training/index.htm> >.

HIV

The CDC estimates that between 850,000 and 950,000 people are living with HIV (PLWH) in the United States. HIV services provide access to people at risk and an opportunity to ensure that people with HIV get the viral hepatitis-related services they need.

HBV rates among PLWH are much higher than those in the general population and vaccination levels are low. People with HIV should be vaccinated against HAV and HBV, since infection can create serious health complications. Although these vaccines are safe for persons who are immunocompromised, the response rate may not be strong enough to provide protection and response to the vaccines tends to decrease as HIV disease progresses. Booster doses of HBV vaccines may be necessary.

According to the 2004 National ADAP Monitoring Report, 22 AIDS Drug Assistance Programs (ADAPs) cover hepatitis A and B vaccine. However, state ADAP programs are facing significant funding shortages so whether additional states will add coverage is unknown.

The National ADAP Monitoring Report is available online at: http://www.nastad.org/pub_careandtreatment.asp?publication_category_id=1&publication_subcategory_id=6.

SECTION III: LESSONS FROM THE FIELD

New York State: Closing the Gap on Adults at Risk for Hepatitis A and B

Immunization, HIV and STD are working together to improve the health of adults at risk for viral hepatitis

In New York State (NYS), adults at risk of hepatitis A and hepatitis B virus infections have access to free hepatitis vaccines through county health department programs. The widespread availability of vaccines for adults is the result of years of collaboration between the New York State Department of Health's (NYSDOH) Immunization, STD Control and HIV Prevention programs. The three programs' commitment to integrating services to reach at-risk adults has enabled NYS to begin closing the gap on adults at risk of hepatitis A and hepatitis B virus infections who remain unvaccinated.

The Adult Hepatitis Vaccination Program began in 1995, when there was a strong focus nationally on immunizing infants, children and adolescents against the hepatitis B virus. The federally funded Vaccines for Children program, which provides free vaccine to eligible children under the age 19 in the United States, was in its infancy, and hepatitis B vaccine school entry requirements were on the docket in many state Legislatures in an effort to capture children and adolescents who were not yet immunized. With a strong national and state focus on infants and children, the NYSDOH Immunization Program was concerned that they not lose sight of at-risk adults who were unvaccinated and susceptible to hepatitis B. (Hepatitis A vaccine was licensed in 1995, but not yet widely available.)

To address these concerns, the Immunization Program allocated state funds to support adult hepatitis B vaccination, and worked with the STD Control Program to implement the vaccine program within county STD clinics. Together, the two programs reached out to the county health departments in the 57¹ upstate counties by letter to inform them of the availability of hepatitis B vaccine. However, the counties were slow to enroll in the program and by 2000, only about 15 counties were enrolled. NYSDOH Hepatitis B Coordinator, Elizabeth Herlihy, explains that the Immunization Program was cautious about encouraging the remaining counties to participate in the program due to the uncertainty of continued vaccine funding for adults at the time.

¹ There are fifty-seven counties that fall under the NYSDOH's jurisdiction. The New York City Department of Health and Mental Hygiene (NYCDOHMH) is responsible for serving the five boroughs of New York City.

During 2001, the NYSDOH's Immunization Program renewed its commitment to adults by expanding the Adult Hepatitis Vaccination Program. This policy decision, Herlihy notes, was consistent with the strong integration messages that hepatitis B coordinators and immunization programs were hearing from CDC at this time. Across the country, at meetings and conferences, coordinators were urged to work with other public health programs (e.g., STD, HIV) to integrate hepatitis activities, including vaccination, into programs already serving adults and adolescents at risk for hepatitis.

The Immunization Program and the STD Control Program again sent a letter to all of the 57 upstate counties encouraging them to join the Adult Hepatitis Vaccination Program, if not already enrolled. As they learned from previous experience, having vaccine available at no cost does not guarantee that all the county health departments will quickly sign up for the program. County health departments are often overwhelmed with day-to-day issues and have little capacity for new initiatives. In addition, targeting at-risk adult populations is often a formidable task. Herlihy, along with regional DOH staff, actively pursued the counties' participation in the program by telephoning, sending follow up letters, and visiting the counties. To date, hepatitis A, hepatitis B and Twinrix® vaccines are being provided at no cost to at-risk adults in 55 of the 57 upstate New York counties, with the remaining two counties poised to join the program this year.

While the Adult Hepatitis Vaccination Program was expanding to STD clinics, the NYSDOH's Immunization Program continued to search for other ways to increase vaccination efforts targeted to at-risk adults and adolescents. In 2002, the NYSDOH AIDS Institute Division of HIV Prevention provided a letter and resource packet to HIV prevention providers explaining the updated STD Treatment Guidelines, which recommended annual STD screenings, HIV testing and hepatitis A and B vaccination for sexually active men who have sex with men. With these recommendations in mind, Herlihy and Susan Klein, Director of the Division of HIV Prevention at the AIDS Institute, began to meet together to discuss how to expand access to vaccine to individuals receiving HIV/AIDS services. In NYS, licensed health care personnel (e.g., physicians, registered nurses, physician assistants) are required to administer vaccine. Because many HIV prevention providers do not have staff who meet these

requirements, HIV providers would likely refer their clients to the public health programs for access to free vaccine.

At this time, several of the county immunization programs, on their own initiative and supported by the NYSDOH, were already successfully working with HIV providers by serving as a referral source for their clients or by providing vaccine onsite at CBOs. Klein and Herlihy decided to formalize the policy encouraging collaboration by sending letters to the county health department immunization programs and to state-funded HIV prevention providers, informing the HIV prevention providers of the availability of free vaccine through county health department programs, and encouraging them to call the local health department for information on how to refer individuals. Karen Schlanger, the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Hepatitis Program Director, also collaborated on the letter and provided information on where to access free vaccine in NYC. The letter (see pages 255–258) offers clear steps on how to integrate hepatitis education and information into HIV programs and services, and provides information on where to get free materials and information on viral hepatitis in NYS.

The letter was sent to HIV prevention providers in August 2003, and Klein reports that the response has been overwhelmingly positive. As Klein notes, “the HIV programs are eager to do anything that they can to help advance the health and well being of the people that they work with in the communities.” The NYS HIV Prevention Planning Group was supportive and encouraged the project to move forward. The NYS Immunization Program, the NYS AIDS Institute and the NYS STD Control Program, however, view the letter as just one of the first steps in an effort that will have to be sustained over time. Ensuring that adults at risk are able to access vaccine requires not only encouraging providers to participate in the program, but also improving hepatitis education and awareness so that both clients and providers understand the risks for hepatitis infections. Further, the NYSDOH must be able to provide the resources, training and technical assistance that is needed by the counties to implement a successful vaccine program.

Several efforts within the NYSDOH will likely strengthen the Adult Hepatitis Vaccination Program. In the past year, Herlihy and Klein developed an interdepartmental work group on hepatitis A and B that includes the NYSDOH STD, HIV and Immunization programs as well as the state Office on Alcoholism and Drug Abuse Services and the Department of Correctional Services. Work group members strategize on how to collaborate to address hepatitis A and B across the state, look for ways



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Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 2003

Dear HIV Prevention Provider:

We are writing to share information about resources for helping to make sure that persons at risk for hepatitis A and B are aware of their risk and know that vaccines to prevent hepatitis A and B infection are available. Due to shared modes of transmission and populations at risk, hepatitis A, B and C are common among persons at risk for or living with HIV. Chronic hepatitis C, along with chronic and acute hepatitis B may be life-threatening and they are the leading cause of chronic liver disease. Hepatitis A can also have serious consequences, especially for people living with hepatitis C. Hepatitis A and B can be prevented through vaccination. Currently there is not a vaccination for hepatitis C, however, the CDC recommends that individuals chronically infected with hepatitis C be vaccinated against hepatitis A and those with risk factors should be vaccinated against Hepatitis B to prevent further liver damage.

Individuals at high risk for hepatitis A for whom vaccination is recommended include men who have sex with men (MSM) and injection drug users (IDUs). Hepatitis B vaccine is recommended for MSM, IDUs, persons who are HIV-infected, sex contacts of persons who are infected with hepatitis B, and those who have multiple sex partners. The CDC recommends that all MSM get vaccinated against both hepatitis A and B. Despite safe and effective vaccines against hepatitis A and B, studies have shown that vaccination rates are low among MSM. Men infected with both chronic hepatitis B and HIV have been found to have extremely high liver-related mortality rates

Availability of Vaccine for Hepatitis A and/or B Vaccination for hepatitis A and/or B is available at many doctors' offices, health care clinics and STD clinics. Often, an individual's health insurance covers costs associated with hepatitis A and B screening and vaccination for high-risk adults. Persons enrolled in the Medicaid or the AIDS Drug Assistance Program (ADAP) are covered for both the antigen screening tests, and the hepatitis A and B vaccines are part of comprehensive primary care visits.

The NYS Department of Health Immunization Program provides free hepatitis A, B, and Twinrix (combination hepatitis A&B) vaccine to local health departments in most upstate counties. The vaccine is targeted for high risk adults and adolescents seeking services through the local health department, including STD clinics and HIV counseling and testing programs. In areas of the state outside of New York City (NYC), call your local health department for information about how to refer individuals at risk for free vaccination.

In NYC, the NYC Department of Health and Mental Hygiene (NYCDOHMH) makes free vaccine available at certain STD clinics. These sites are identified on the attached listing. Hepatitis B vaccine is available to anyone. Hepatitis A vaccine is limited to MSM, IDU and persons living with HIV and/or liver disease. The NYCDOHMH also distributes hepatitis vaccine to some HIV prevention programs. To explore access to vaccine for your organization, you can call Dr. Stephen Friedman at 212-676-2256 or Dr. Jane Zucker at 212-676-2248.

We encourage you to reach out to the NYCDOHMH or to your local health department, to obtain specific information about how individuals can access free vaccine.

Free Materials and Training About Hepatitis A and B Attached are reference sheets that highlight how to access free materials and training about hepatitis A and B and access to free vaccine within NYC.

Action Steps It is important for MSM, IDUs, individuals with HIV, individuals with hepatitis C, and other persons at high risk for hepatitis A and B to be aware of their risk and to be informed of the availability of antigen screening and vaccine against Hepatitis A and B. Please consider ways in which you can incorporate information about hepatitis A and B into your programs and services. For example:

- Offer clients clear information about how to avoid exposure to viral hepatitis as part of prevention counseling.
- Incorporate information about hepatitis A and B into their risk reduction presentations, especially in/at venues where high risk populations gather;
- Make brochures and information about hepatitis A and B available to clients;
- Educate active IDUs and MSM about vaccination;
- Refer active IDUs to syringe exchange programs and/or ESAP pharmacies for clean injection equipment;
- Provide information about free vaccine available from local health departments;
- Provide HIV-infected individuals and their partners information about hepatitis A and B and referrals, where appropriate, as part of case management; and
- Use materials about hepatitis A and B as part of a discussion on maintaining health behaviors in MSM support groups and support groups for HIV-infected individuals.

We appreciate your assistance in informing individuals about hepatitis A and B, helping them assess their risk(s) and aiding them in accessing vaccine.

Sincerely,



Susan J. Klein, M.S.
Director, Division of HIV Prevention
AIDS Institute



Elizabeth J. Herlihy, R.N., M.S.
Hepatitis B Coordinator
Immunization Program

Additional Resources: Materials and Training Related to Hepatitis A and B

Free Materials About Hepatitis A and B A variety of print materials about hepatitis A and B are available in camera ready format and copyright free from the Immunization Action Coalition. The Immunization Action Coalition maintains a web site at: www.immunize.org. Materials suitable for use with adults who may be at risk include the following items:

Item #	Title
P4035	Immunizations...Not Just Kids' Stuff
P4041	Shots for Adults with HIV
P4080	Hepatitis A is a Serious Liver Disease: Should you be Vaccinated?
P4112	Every Week Thousands of Sexually Active People Are Infected with Hepatitis B: Get Protected! Get Vaccinated!
P4115	Hepatitis B: 100 Times Easier to Catch than HIV!
P4116	You Don't Have to go All the Way to Get Hepatitis A: Get Vaccinated!

The Gay and Lesbian Medical Association provides information about hepatitis A and B, as well as resources for creating a safe clinical environment for LGBT clients at: www.glma.org.

The NYS Department of Health Immunization Program recently established a Viral Hepatitis Web Site. To access it, visit: <http://www.health.state.ny.us/nysdoh/hepatitis/en/index.htm>

The NYS Department of Health AIDS Institute offers a brochure, "Diseases that Can Be Spread During Sex" (publication 3805), that highlights risks, symptoms and recommendations for hepatitis B vaccination. This brochure is available in English and Spanish can be obtained through the HIV/AIDS Consumer Educational Materials Order Form, available by calling 581/474-9866 or by e-mail directed to: hivpubs@health.state.ny.us. AIDS Institute "Questions and Answers" on viral hepatitis and HIV can be found on the web at:

http://www.hivguidelines.org/public_html/center/clinical-education/clinical-education.shtml

The Centers for Disease Control and Prevention offers fact sheets for hepatitis A and B on-line at:

<http://www.cdc.gov/ncidod/diseases/hepatitis/a/fact.htm>
<http://www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm>

Training for Staff The AIDS Institute offers a free, half-day training entitled "The ABC's of Hepatitis and HIV". To view the Statewide Calendar of HIV/AIDS Trainings on the Internet go to: <http://www.health.state.ny.us/nysdoh/aids/training.htm>.

Hepatitis A and B Vaccine , Materials and Training Available Through the New York City Department of Health and Mental Hygiene

Free hepatitis A and B vaccine: Free hepatitis A and B vaccine is available at the three NYC DOHMH STD Clinics listed below. Hepatitis B vaccine is available to anyone. Hepatitis A vaccine is limited to men who have sex with men, people who inject drugs, and people with HIV and/or liver disease.

Riverside STD Clinic
160 West 100th St., 1st Floor
Manhattan
(212) 865-1951

Morrisania STD Clinic
1309 Fulton Ave., 2nd Floor
Bronx
(718) 901-6564

Crown Heights STD Clinic
1218 Prospect Place, 2nd Floor
Brooklyn
(718) 735 0580

Gay men/men who have sex with men can also get hepatitis A vaccine at the Chelsea STD clinic and hepatitis B vaccine from the Chelsea immunization clinic, open Monday and Friday. The Chelsea STD clinic is located at 303 9th Avenue, 2nd Floor (at W. 28th St.). Call (212) 239-1718 for details.

Free Promotional Materials: Free fact cards that list NYC DOHMH STD clinics where hepatitis A and B vaccination and hepatitis C testing are offered and provide basic information on hepatitis A, B and C can be ordered by calling (212) 427-5120.

Training for Staff: The HIV Training Institute offers a free full-day training entitled "Hepatitis C: A Training for Service Providers". Call (212) 341-9810 or e-mail: losborne@health.nyc.gov to obtain a schedule or to register.

For Further Information About Hepatitis C in New York City: Please contact:

Karen Schlanger, M.P.H.
Director, Hepatitis C Program
NYC Department of Health and Mental Hygiene
125 Worth Street, CN-22, Room 326;
New York NY 10013.
Telephone: (212) 227-6021

to develop policies that support hepatitis integration within each of their programs, and educate their constituencies in the counties of hepatitis A and B resources, including vaccine availability.

The NYSDOH Bureau of STD Control Program, for example, has taken a leading role in educating its providers about viral hepatitis and the availability of free vaccine. Over the past nine months the STD Control Program held a series of “STD Clinician Training Programs” throughout upstate New York. These trainings were targeted towards physicians, nurse practitioners, nurses and other providers working in HIV and STD. Information on viral hepatitis was incorporated into three of the presentations given at the training, and the informational packets given to participants included the “Dear HIV Prevention Provider” letter written by Klein and Herlihy and a hepatitis C informational letter written by Marilyn A. Kacica, MD, Medical Director of the NYSDOH Regional Epidemiology Program.

Another ongoing collaboration, soon to come to fruition, is the development of the NYS Viral Hepatitis Strategic Plan. A core group of representatives from several of the Programs, Centers and Divisions at NYSDOH led the writing of the plan, and approximately 65 stakeholder groups from across NYS, including the NYCDOHMH, were involved and provided input into the plan. The plan covers five years and has four major components: Prevention, Education, Surveillance and Research, and Medical and Case Management.

This year, the NYS Immunization Program is incorporating language into its contracts with the counties requesting that they assess hepatitis immunization needs within their community and provide hepatitis vaccines to at-risk adults through participation in the Adult Hepatitis Vaccination Program. Other current initiatives by the Immunization Program include a hepatitis vaccine pilot project with 11 county jails and a survey of all 57 upstate counties to assess their involvement in health services provided at their county jails. The purpose of this study is to assess feasibility of local health departments providing hepatitis vaccination services at their county jails.

As the NYS experience shows, having hepatitis A and B vaccine available for adults is only one component needed in an adult hepatitis vaccination program. Getting busy

county health departments, STD clinics and HIV programs to provide vaccine or referrals to vaccine requires considerable communication, follow-up, education and resources. The leadership, commitment, supportive policies and prioritization of funds demonstrated by the NYSDOH Immunization, HIV Prevention and STD Control programs were all critically important to the success of the Adult Hepatitis Vaccination Program. With all of this in place, NYSDOH is now well positioned to close the gap on adults at risk of hepatitis A and B virus infections through the provision of hepatitis vaccines.

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Lessons Learned

- Convincing providers to participate may require multiple requests and ongoing education to increase their awareness about viral hepatitis and the role they can play in prevention efforts.
- Provide clear directions and a step-by-step process on how providers can participate in prevention efforts.
- Some providers will need resources, training and technical assistance to implement successful vaccination programs.
- A work group can focus key stakeholders on the issue, allowing members to strategize on how to collaborate, develop policies that support hepatitis integration, and educate their constituencies.
- A strategic plan can provide a clear road map that facilitates buy in and sustaining of programs.
- Needs assessment can help identify populations in need of vaccination services.
- Outreach and education efforts also need to target at-risk adults so they are aware of the risk they face and are motivated to get vaccinated.
- During program integration, clinicians (physicians, nurse practitioners and nurses) require training on viral hepatitis and vaccination so they can effectively educate clients. Awareness efforts should not just focus on stakeholders and administrators.

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